BI-STATE PRIMARY CARE ASSOCIATION

SERVING VERMONT & NEW HAMPSHIRE

MEMORANDUM

TO: **Members of the House Health Care and Senate Health & Welfare Committees**
Members of the Health Access Oversight Committee
Members of the Health Care Reform Commission
Cynthia LaWare, Secretary, Agency of Human Services
Susan Besio, Director, Health Reform Implementation
Joshua Slen, Director, Office of Vermont Health Access
Christine Oliver, Deputy Commissioner, Health Care Administration

DATE: November 15, 2006

FROM: Tess Kuenning, Executive Director
Hunt Blair, Vermont Director of Public Policy

RE: **Report on Medicaid & Catamount Outreach**
As specified by Vermont 2006 Act 215, Sec. 342.

Attached, please find the *Medicaid & Catamount Outreach* report, a review of current conditions, best practices nationally, and recommendations for improved outreach and enrollment strategies and tactics in Vermont.

Bi-State Primary Care Association is pleased to have had the opportunity to prepare this report at the legislature's request. This project was a collaborative effort. We want to take this opportunity to thank all the members of the work group who participated in meetings throughout the late summer and fall. They diligently reviewed multiple drafts of the report as it evolved into its final form, and provided extensive insight, creative suggestions, and genuine enthusiasm for moving ahead with implementation of improved outreach efforts for Medicaid and the new Catamount health plan. In addition, a group of key informants provided additional insight, background information, and critiques of the report. All of these individuals are listed in Appendix D, and again, we thank them all for their significant contributions to the final product.

The work group members are excited about the prospects for creating a comprehensive outreach effort that can effectively reach and enroll currently uninsured Vermonters. The Recommendations section is essentially an outline for an outreach and enrollment implementation plan. Bi-State and our work group collaborators look forward to working with, and supporting, the efforts the legislature and administration as you move forward with the critically important efforts to extend health care coverage to all eligible, uninsured Vermonters.

BI-STATE PRIMARY CARE ASSOCIATION

SERVING VERMONT & NEW HAMPSHIRE

Working for 100% Access to Health Care

Medicaid & Catamount Outreach:

A Report to the Legislature and Agency of Human Services

November 15, 2006

Supported by funding from:
The Health Resources and Services Administration,
Bureau of Primary Health Care

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I. Executive Summary

The *Medicaid & Catamount Outreach* report is a review of current conditions, best practices nationally, and recommendations for improved outreach and enrollment strategies and tactics in Vermont. This report reflects the collective wisdom of many colleagues who formed an *ad hoc* work group convened by Bi-State and who shared their knowledge and ideas at meetings and through on-line review of successive drafts of the document. The work group's core recommendation for outreach and enrollment in both Medicaid and Catamount is to **approach the continuum of uninsured individuals with a continuum of coverage solutions** that are comprehensive, consumer friendly, and include both a broad public education campaign and highly targeted assistance aimed at reaching individuals "where they live, work and play."

Current outreach and enrollment efforts for Medicaid face multiple structural impediments, including difficulty obtaining accurate, up-to-date information, the need for one-on-one assistance in completing the enrollment process, and the capacity to track and follow-up applications to assure that prospective applicants do not "fall through the cracks" if they encounter difficulties in completing enrollment.

The work group urges adoption of a comprehensive program integrating outreach and enrollment for both Medicaid and Catamount. The plan can be distilled down to six recommendations:

1. Establish Outreach as a Policy Priority: Make systematic, comprehensive outreach a high priority in state government and leverage resources through public/private partnerships that can facilitate and extend outreach and enrollment activities.
2. Assure Agency-wide Coordination of Message: Provide accurate, up-to-date information on the web and in print.
3. Create a Comprehensive Marketing Plan: Develop a comprehensive public education program that includes all Vermont's health programs in a coherent, consistent, unified marketing campaign.
4. Enable Web-based Tools: Create or adapt a web-based screening and enrollment/application tool.
5. Institute Applicant Inquiry Tracking: Structure the enrollment process so that wherever the uninsured or underinsured present or are identified, once they are initially screened and their basic demographic data is captured, the burden of follow up rests with the enrollment system, not with the individual.
6. Deploy One-on-One Outreach Coordinators: Utilize a combination of volunteer and professional Outreach Coordinators who are trained to work one-on-one with potential applicants to screen them and provide counseling and support in the enrollment and application process.

If you have comments on or questions about this report, please contact:

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II. Report Purpose

During the 2005-2006 Vermont legislative biennium, frequent references were made to "eligible but not enrolled" individuals: Vermonters eligible for public health care benefits through Medicaid who are nonetheless not enrolled. While often discussed, policy analysts and those with outreach expertise do not always agree about why these individuals do not take advantage of the available benefits, or how to best reach them.

As part of the health reform legislation debate, many theories were put forward to explain the behavior of the "eligible but not enrolled" population, and while there was disagreement about the causes, there was agreement that more effective outreach to eligible beneficiaries would be of benefit. Accordingly, the following Section is included in the Appropriations Act:

> Act 215, Sec. 342. MEDICAID OUTREACH
> (a) Bi-State Primary Care Association, in consultation with the medical care advisory committee established in section 1901c of Title 33, will research efforts in Vermont and in other states that have succeeded in enrolling individuals eligible for Medicaid and Medicaid waiver programs. The association will report its findings and recommendations to the house committee on health care, the senate committee on health and welfare, the health access oversight committee and the agency of human services no later than November 15, 2006.

The passage of Act 191, creating the Catamount Health Plan (Catamount), introduces further opportunities to consider outreach to and enrollment of uninsured Vermonters. At the request of Susan Besio, Director of Health Reform Implementation, and with the concurrence of legislative leadership, this report's scope widened to include Catamount as well as Medicaid programs. For reasons detailed below, it does not make sense to consider outreach efforts for one program separate from the other.

In the past, Vermont – often in collaboration with external organizations, such as the Robert Wood Johnson Foundation (RWJF) Covering Kids & Families initiative – has invested resources in outreach. Indeed the record for enrollment of children in the Dr. Dynasaur Medicaid expansion program is impressive. According to the Kaiser Family Foundation's statehealthfacts.org website, Vermont covers 40% of children 0-18 through Medicaid and other public programs, with just 6% of Vermont's children uninsured. Nationally, 12% of children 0-18 are uninsured, with only 27% covered by Medicaid and other public programs.

Given that track record, many agree that Vermont can and should do better enrolling eligible uninsured adults in Medicaid and decrease the percentage of uninsured children yet further. This report explores current impediments to enrollment, and it provides recommendations for improved outreach to Vermont's uninsured in order to make the most of our new and existing public health assistance programs.

III. Process

Bi-State Primary Care Association (Bi-State) convened a work group that met in the summer and fall of 2006. Members of the Medicaid Advisory Board (M.A.B.) were notified at their June meeting about the effort, the statutory expectation that M.A.B. members participate, and invited to attend. Several M.A.B. members subsequently joined the work group, as did representatives from Federally Qualified Health Centers, the Coalition of Clinics for the Uninsured, the Office of Health Care Ombudsman, Vermont Public Interest Research Group, and the Vermont Department of Health.

At Director Besio's suggestion, Bi-State engaged in conversation with other organizations interested specifically in Catamount outreach initiatives. Through those discussions, representatives of Vermont AARP, the Vermont Campaign for Healthcare Security, the Vermont NEA, and the Vermont Citizens Campaign for Health also joined what became a combined Medicaid/Catamount outreach work group.

Bi-State also contacted an inter-agency work group led by the Office of Vermont Health Access (OVHA) that is currently working on outreach initiatives. OVHA is charged with contacting "eligible but not enrolled" respondents[1] to the Division of Health Care Administration *Household Health Insurance Survey*. In addition, members of the Report work group also participate in a "Youth In Transition" work group addressing gaps in Medicaid coverage for Medicaid eligible young adults (18-21) who "age out" of Dr. Dynasaur or otherwise become uninsured. The work of both of those groups is reflected in the findings and recommendations of this report.

Bi-State conducted a literature review of best practices and other policy issues related to outreach for public health insurance programs and met with Amy Rosenthal, Director of the New England Alliance for Children's Health, a project of Community Catalyst, to seek information on other outreach efforts being undertaken in the region. (See also Appendices A and B)

In addition, Bi-State and work group members were invited by Director Besio to engage in broader discussions about outreach, marketing, and public education for the programs, prompted by interest in Vermont's reform initiatives from Alice Burton, Director of the State Health Policy Group at AcademyHealth, where she leads the RWJF State Coverage Initiatives (SCI) program. Those discussions also inform the findings and recommendations of this report.

[1] That resurvey will be conducted in the fall of 2006.

IV. Findings and Observations

This section includes findings and observations for five areas:

A. Data on Medicaid Eligible Uninsured,
B. Obstacles to Accessing Information,
C. Personal Contact and Follow Up,
D. Current and Recent Vermont Outreach Efforts, and
E. Essential Components for An Integrated Outreach System.

A. Data on Medicaid Eligible Uninsured

The *2005 Vermont Household Health Insurance Survey: Final Report* (August, 2006)[2] includes "analysis conducted to evaluate the characteristics for enrollment in Medicaid, Dr. Dynasaur, or VHAP," the Vermont Health Access Plan, that provides significant data to enlighten the conversation about the eligible but uninsured population. The *Survey Report* provides a wealth of information worth reviewing in depth. Highlights include:

- Nearly 60% of uninsured Medicaid eligible adults ages 18 to 64 are male.
- Over 50% of uninsured Medicaid eligible children are between 11 to 17 years of age.
- Over half of uninsured Medicaid eligible adults are between 25 and 49.
- Nearly 60% of uninsured Medicaid eligible adults ages 18 to 64 have family incomes less than 100% of the Federal Poverty Level.
- Nearly eight in ten uninsured Medicaid eligible adults ages 18 to 64 work for pay, tend to work full time, and are employed mostly by private companies. Most work in the service or retail sector. Most work for firms with 25 or fewer employees, although over 20% work for firms with 100 or more employees.
- Nearly 40% Medicaid eligible adults ages 18 to 64 indicate their employers offer some type of health insurance. Most indicate cost is a barrier to coverage through their employer.

B. Obstacles to Accessing Information

The reasons eligible individuals remain uninsured and do not enroll in public health programs are nearly as diverse and widespread as the individuals themselves, but members of the work group unanimously agree that, from a consumer perspective, obtaining easily understood, up-to-date, readily accessible information about Vermont Medicaid programs can be challenging.

Decades of Medicaid program policy changes at the federal and state level has created layers of programs that each have differing "tests" for eligibility. An uninsured or under-insured individual seeking public assistance is unlikely to know where they "fit" in a continuum that includes dozens of different categories of eligibility screens. Vermont

[2] http://www.bishca.state.vt.us/hcadiv/Data_Reports/healthinsurmarket/2005_VHHIS_Final_080706.pdf

Medicaid and its expansion programs form a complex web of eligibility and means tests that involve financial status (in some cases earnings, in other cases earnings and means), health status, and other criteria that determine the application outcome.

Even within the world of the professionals who spend much of their day counseling individuals and providing assistance navigating the system, confusion about benefit levels and eligibility for the various programs is common. While Act 191 improves access with the creation of Catamount, the additional complexity of eligibility for the Catamount Health Assistance Program (CHAP) and – if approved – Employer Sponsored Insurance (ESI), add another layer of potential confusion.

For consumers, the system verges on the incomprehensible. This is born out by the *Survey Report's* finding that "nearly 70% of families with uninsured Medicaid eligible children are very interested in enrolling…; however, over half believe they would not meet eligibility requirements." Clearly, Vermont can do a more effective job of helping consumers overcome the barriers preventing them from accessing public insurance benefits.

Obstacles to successful enrollment in Vermont's public health programs include:

- Lack of, or difficulty accessing, easy-to-understand information on Medicaid programs,
- Out-of-date and confusing information on state web sites focused on enrollment in public heath programs,
- Lack of access by uninsured individuals to computers and web sites, and a lack of knowledge on how to navigate relevant sites,
- Lack of a comprehensive process to follow-up with applicants in search of information or direct assistance, and
- Both advocates and bureaucrats conversant in, and often focused on, policy information that is not useful or meaningful to the consumer.

Many people in, and departments of, state government are doing good work individually, but there is not an over-arching, Agency-wide coordination of Medicaid outreach and enrollment. This lack of a comprehensive, coordinated approach surfaces in multiple settings. Phone information/assistance, written materials, and web-based information could all benefit from better coordination and a focus on the consumer end user.

B.1. Phone Information/Assistance

- A toll free 800 phone line is available to request an application from "Vermont Health Access Member Services" (staffed by the contractor, Maximus), but the line is only answered between 7:45 a.m. and 4:30 p.m., Monday through Friday. Members of the work group reported significant wait times on hold that could further deter applicants, as well as lack of access during evening hours and weekends. Many eligible but not enrolled individuals do not have the opportunity to make phone calls during the day because of workplace limitations.

- In addition to long wait times on the telephone, callers bring a host of complex needs and issues to their pursuit of information about and assistance with the Medicaid application process. (Members of the work group and others consistently report Maximus phone staff are helpful and able to clarify written materials.) There is a high degree of complexity the staff at Maximus attempts to deal with, but more could be done to build on the existing infrastructure of Member Services, like adding more capacity, to enhance the effectiveness of telephone assistance. A consumer who reaches a Maximus customer service person is advised that an application can be sent out by mail or secured directly at an AHS office. Maximus staff does not process applications over the telephone, but are available, to some extent, to help "walk" applicants through the process.

B.2. Written Materials

- While the state produces and distributes brochures to publicize the programs, information in the brochures can age rapidly and become out of date. One of the current Dr. Dynasaur brochures, for instance, has year old federal poverty level guidelines that no longer reflect current income eligibility criteria, but similar information distributed by a different department is current.

- The application forms could be streamlined and made more clear. One form is 20 pages – including not only a health program application but also sections for Food Stamps, Reach Up, and other programs – and it is somewhat intimidating because of its length. Another application is only six pages, but the two largest images at the top of the first page are the WIC (Women Infants Children) program logo and the Dr. Dynasaur logo, and it is headlined "Application for WIC and Health Care Programs." A male adult might not perceive it as an application for his use.

B.3 Web-based Information

- Although OVHA's web site is recently updated, as are the Economic Services Division (ESD) of the Department of Children and Families (DCF) pages, until very recently, clicking on a link labeled "Medicaid Information Online" from one AHS page led to a Department of Prevention, Assistance, Transition and Health Access (PATH) web page. (PATH has not existed as a department of AHS for several years.)
- The links to PATH pages were eliminated this fall, but work group members noted that until those recent changes were made, much of the information on AHS pages was out of date. For instance, a link marked "Eligibility" on a page with information about Dr. Dynasaur led to a PATH page with the note: "Content Updated 10/28/2002." The income level criteria – a key element of eligibility – displayed on the eligibility information page was years out of date.
- Clicking on "Help for Vermonters," a link at the top of many AHS pages, leads to a page that has, among other things, a link for Dr. Dynasaur but not a direct link to Medicaid or VHAP. There is no indication that Dr. Dynasaur is a health care program. The consumer seeking health care information would already have to

be familiar with the program's name.

- The Dr. Dynasaur page does have, at the bottom of a *long* scroll-down list, links to VHAP and other Medicaid health programs. But in general, throughout the AHS site, it is far more difficult to figure out how to click through to information about VHAP and adult Medicaid programs than to find information on Dr. Dynasaur.
- The DCF page contains a link labeled "click here for an application you can print, fill out, and bring to a DCF office." It does not note that the 20 page application can be mailed in, but the form itself does. The six page WIC and health care programs application does not appear to be available on-line.
- The DCF site may, because of its name, be an impediment to access itself. Adults without children may not realize that the department of *children and families* is the unit of state government that processes all Medicaid, VHAP, and Dr. Dynasaur applications, regardless of the applicant's age or family status.
- Another link on the DCF page (and on other AHS pages) asks: "Can't decide which programs you might be eligible for? Try our Screen Door online referral tool." This is an admirable effort to demystify an array of AHS programs. The Screen Door interface is not, however, user-friendly for individuals with limited literacy and it does not focus on persons with health care access problems. An uninsured individual seeking state health care assistance is not directed to information about those programs by the Screen Door. In fact, the Screen Door has no mechanism to do so: its initial query pages do not ask about being uninsured, and then several pages into the screen, the reader is asked what Medicaid programs (VHAP, Dr. Dynasaur, etc.) the person completing the form already has.

- Several links from the Dr. Dynasaur page are problematic. These links,
  - History of program,
  - State Children's Health Insurance Program (SCHIP) Plan, and
  - State Children's Health Insurance Programs Background

  lead to documents of more interest to policy makers and analysts than to uninsured seeking information about coverage. These include various documents filed with Centers for Medicare and Medicaid Services (CMS) and other materials of no importance to uninsured individuals seeking information about accessing coverage.

- Links to the VHAP page are similarly confusing, with more "policy detail" links than the Dr. Dynasaur page – including multiple sections of the VHAP 1115 waiver (itself now replaced by the "Global Commitment to Health" 1115 waiver).

- Many Agency web pages contain information for both external and internal audiences. For instance, links to "GroupWise" and the "AHS Intranet" can be confusing for consumers and lead to dead ends that can discourage further browsing.

- As challenging as these situations are, a more fundamental concern is that many uninsured individuals lack access to computers and web sites, are not able to navigate them if they can access the sites, and face profound challenges in following up on whatever information they are able to glean from the sites.

C. Personal Contact and Follow Up

The direct experience of social workers, advocates, health care provider staff and others who assist uninsured with their applications is that there is no substitute for one-on-one contact with the applicants. The experience of members of the work group and interviews with others contacted in researching this report is that successful completion of an application requires a substantial amount of assistance to help individuals complete the process. Suggested starting points for how to accomplish this are included in the Recommendations section. A critical element for an effective, successful "application support system" will be establishing a clearly articulated process for referring potential applicants to those support mechanisms.

At present, there is not a system in place for providing application and enrollment assistance in a consistent fashion. Vermont has a patchwork of agencies and individuals who provide some level of assistance, but there is not a system for assuring that it is provided consistently across the state in multiple settings.

In the context of these challenges, the introduction of the Catamount Health plan, the Catamount Health Assistance Program, and the potential Employer Sponsored Insurance programs bring further complexity into the landscape for uninsured Vermonters and those who seek to assist them.

D. Current and Recent Vermont Outreach Efforts

D.1. Vermont Department of Health

As mentioned above, Vermont has had remarkable success insuring children through the Dr. Dynasaur program. Outreach efforts led by the Department of Health (VDH) under the RWJF Covering Families & Kids initiative produced many successes. The key lessons learned from those efforts are: they work, but – not surprisingly – enrollment growth begins to decline as soon as they are curtailed.

The VDH, via the schools, annually sends home information to every school-aged child in Vermont about Dr. Dynasaur. Posters with the Member Assistance 800 number and prepaid postcards that parents can send in requesting information are distributed to schools. The "School Health Entry Form Health Appraisal of Students" asks parents if the student has health insurance.

In 2004, the VDH tracked requests for Dr. Dynasaur applications. Of 535 applications sent out, 151 were returned and approved, 20 were denied, 41 were covered at the time of

the mailing, and there was no record of an application in the system for 323. VDH then surveyed those 323 "missing applicants," garnering an impressive response rate of 108 individuals. 14 of those had applications approved or pending by the time of the survey. Reasons given by the others for not applying included:

- "Never received application, still interested" (16)
- "Still considering applying" (22)
- "No longer interested" (12)
- "Confident not eligible" (9)
- "Confused about eligibility, still interested" (12)
- "Lost the application, still interested" (6)
- "Has other insurance, did not know about Dr. D. as back up, still interested" (5)
- "Never requested information, not interested" (4)

A scattering of other reasons were given by single respondents, including "waiting to do taxes before applying," "too expensive," "not interested, citing political reasons," "checking to see if providers accept," "requested the application for research purposes only."

The feedback from this survey should not obscure the excellent work being done by the VDH – and by other Agency departments – to reach the uninsured and support Medicaid enrollment efforts. The lessons learned from the VDH can help build a better, more comprehensive system integrated across state government and community partners[3].

D.2. Vermont Coalition of Clinics for the Uninsured (VCCU)

The Vermont Coalition of Clinics for the Uninsured (VCCU) is a key "front line" partner in the existing Medicaid outreach and enrollment structure. Grants that convey legislative appropriations to the free clinics stipulate outreach and enrollment outcome measures and support the critical work the clinics do in screening and benefits counseling.

In 2005, VCCU clinics served 4,487 patients with 12,501 patient services visits and 4,689 referrals. All VCCU sites serve as an entry point for systematic health care by carefully screening clients and helping to enroll them in Medicaid or Medicaid extension plans such as VHAP, Dr. Dynasaur, and Ladies First. In 2005, VCCU clinics conducted 3,869 screenings for Medicaid eligibility and assisted 2,177 individuals with enrollment through direct case management.

The free clinics also provide enrollment counseling for the various Patient Assistance "free drug" Programs (PAPs) sponsored by pharmaceutical manufacturers, providing $707,051 of free prescriptions to un- and underinsured Vermonters in 2005[4].

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[3] VDH has played an active role in outreach and enrollment since a 1976 court order and should remain an essential element of an integrated, Agency-wide response to improving outreach.

[4] Enrollment in the PAPs is notoriously complex, with different eligibility criteria for different manufacturers. Because of the complexity of the system, now including the variable factor of Medicare Part D, many consumers need assistance performing what can often be a sophisticated cost/benefit analysis

The Coalition clinics stand ready to add Catamount to the menu of potential benefits from which their patients may benefit. As importantly, the clinics will be a critical source of information and feedback for enrollment efforts. By definition, the free clinics for the uninsured are where the target population can be found, so information about what gaps the new and existing programs do not fill will be highly pertinent to further efforts to expand coverage.

D.3. Primary Care Provider Outreach

Federally Qualified Health Centers (FQHCs), since they serve all patients, regardless of ability to pay, on a sliding-fee-scale basis, routinely assist their patients with benefits counseling, identifying likely potential Medicaid beneficiaries and providing assistance in completing applications.

The Community Health Center of Burlington (CHCB), for instance, employs staff with specific outreach roles. CHCB is among the most active organizations utilizing the existing on-line application procedure and routinely follows up with patients after the applications are submitted to monitor enrollment status.

Rural Health Clinics (RHCs), which are frequently the only health care provider in their rural communities, also provide assistance to their patients, making sure they have complete information about the programs and assisting with applications. Most RHCs do not have on-site staff with the specific role to perform that assistance, but many have staff that take on that role or at least help guide patients to local resources where assistance is available. Many hospital-related RHCs – and other hospital owned primary care practices – are able to direct patients to resources within their hospital system who can provide application counseling.

Other primary care practices, particularly pediatric practices, at a minimum typically have information on VHAP, Dr. Dynasaur and the other Medicaid programs on hand, and many private primary care practices provide outreach, at least on an informal, *ad hoc* basis. In many cases, front desk or finance office staff provide assistance to their patients and/or direct them to local resources. In some practices, benefits counseling is available through pilot programs that locate social workers in the primary care settings.

By providing a more coherent, comprehensive outreach and enrollment structure for primary care practices to fit into, the state can easily leverage the willingness and desire of these health professionals to see their patients gain access to benefits for which they qualify. There are many opportunities for improved outreach programs to collaborate with the expanding practice-level infrastructure of social workers and other support staff

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to determine which strategy is best for their needs. In a separate initiative with the Heinz Family Philanthropies, Bi-State is exploring ways to create a comprehensive statewide pharmacy program blending the benefits of the federal 340B pharmacy program with PAPs and other mechanisms. This effort will be integrated into whatever comprehensive outreach and enrollment plan moves forward for Medicaid and Catamount.

associated with the Vermont Blueprint and other initiatives.

E. Essential Components for Building an Integrated System

During the course of the work group's meetings and discussions among multiple participants, several key themes emerged:

- Uninsured "present" along a continuum – some are Medicaid, VHAP or Dr. D. eligible one month and then the next month they may have earned too much income and be ineligible – and as a rule, they do not know which program is which. And really, why should they? Even the experts have trouble keeping our alphabet soup of Medicaid and Medicaid expansion programs straight. Keeping track of these eligibility lines and criteria will be even more complicated when Catamount comes online.
- Whatever outreach strategies are adopted, they have to take into account that neither the uninsured themselves nor the first person "in the system" whom they contact or who contacts them will know, immediately, what program fits their needs, or more to the point, what program they fit into.
- It is the unanimous observation of everyone on the work group and everyone with whom we spoke that one-on-one assistance is a critical element for success in outreach and enrollment, because (as the evidence from the VDH survey demonstrates) it frequently takes *guidance and assistance* for someone to successfully "enter the system."
- It is essential that the intake system be able to track individuals, so that those who lose their way or drop off are found. It should be designed so that individuals are never told "call somebody else." It should be constructed so that a base line of questions are asked, including, "what is a number for us to have someone call you back?" Outreach means out-bound calling, not only an 800 number with "operators standing by" for the calls.
- As the work group's conversation evolved, it defined two important marketing constituencies: the *primary* audience (the potential applicant or recipient), and the *secondary* audience, such as health care providers and professionals, community organizations, clergy, human and social services professionals, and others in a position – or interested in being in a position – to assist in outreach to the primary audience. A comprehensive outreach and enrollment campaign requires effective communication to both audiences, but the messages and means of delivery will vary for each.

V. Recommendations

This section includes a recommended "guiding principle" for outreach, and specific recommendations in six areas:

1. Establish Outreach as a Policy Priority
2. Assure Agency-wide Coordination of Message
3. Create a Comprehensive Marketing Plan
4. Enable Web-based Tools
5. Implement Applicant Inquiry Training
6. Deploy One-on-One Outreach Coordinators

The Section provides further detail on strategies for structuring outreach coordination, out-stationed eligibility and enrollment, leveraging resources, and additional considerations and recommendations.

A. Continuum Approach: The Guiding Principle

The work group's overarching principle for outreach and enrollment in both Medicaid and Catamount is to **approach the continuum of uninsured individuals with a continuum of coverage solutions**. It is often less than clear at first glance what benefit coverage level and eligibility criteria applies to a given uninsured Vermonter.

Rather than thinking of the uninsured in discrete target segments for whom there is a single "product," we need to recognize that criteria for eligibility for public assistance and Catamount runs along a complex, dynamic continuum, depending on multiple factors of income, financial resources, employment, family size, and other variables. Indeed, individuals' lives, work, employer, and income status also run along a dynamic continuum that can effect their eligibility, sometimes month to month. It is well documented and acknowledged that many public insurance beneficiaries "churn" on and off the programs for numerous reasons.

Because of this, neither a "one size fits all" nor a "Category A, B, C coverage for Category A, B, C beneficiaries" approach will work. The work group recommends design of a nuanced response that recognizes the underlying complexity of program eligibility. As important, the system must identify, capture, and retain information about all inquiries and referrals.

The system must be designed to identify individuals who "fall between the cracks" and assure that once identified, their enrollment process is facilitated to a successful, accountable conclusion.

B. Prioritized Action Steps

The work group's primary recommendations are to:

1. Make systematic, comprehensive outreach a high priority in state government and leverage resources through public/private partnerships that can facilitate and extend outreach and enrollment activities.

2. Provide accurate, up-to-date information on the web and in print.
3. Create a comprehensive public education program that includes all Vermont's health programs in a coherent, consistent, unified marketing campaign.
4. Create or adapt a web-based screening and enrollment/application tool.
5. Structure the enrollment process so that wherever the uninsured or underinsured present or are identified, once they are initially screened and their basic demographic data is captured, the burden of follow up rests with the enrollment system, not with the individual.
6. Utilize a combination of volunteer and professional Outreach Coordinators who are trained to work one-on-one with potential applicants to screen them and provide counseling and support in the enrollment and application process.

These priorities are further detailed in the following pages.

B.1. Establish Outreach as Policy Priority

Make outreach and enrollment a statewide priority within government and with government agency partners. The most essential element to success is the commitment of state leadership, inside government and out, to implementation of a comprehensive outreach and enrollment plan.

B.2 Assure Agency-wide Coordination of Message

Assure Agency-wide orchestration of outreach efforts with accurate, up-to-date web-based and written materials.

a. Locate authority and responsibility for coordination of all departments' outreach efforts at the Agency level, for example, creating a special assistant to the AHS Communications Director to oversee outreach marketing within state government or an assistant to the Director of Health Reform Implementation.
b. State web sites need to be consumer focused. Ideally, a separate consumer-specific web domain should be established (with many, clearly marked links from all AHS web pages). The example is medicare.gov, which is distinct from cms.gov. The former is for consumer information, the latter for technical and policy pages.
c. Improve integration of health benefit program information with the AHS "Screen Door," the United Way's "Vermont 211" web portals, and other state agency web pages.
d. Assure web-based and written information is consumer-friendly and understandable, does not include extraneous information, and is appropriately targeted for the literacy level of its audiences.[5]

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[5] 50% of adults over age 16 have difficulty using print materials to accomplish everyday tasks according to the National Assessment of Adult Literacy (NAAL) http://www.nifl.gov/nifl/NAAL2003.html A key NAAL recommendations is that recipients of programs, etc be involved in the writing of the documents and that the documents are evaluated by recipients BEFORE they are finalized.

B.3. Create a Comprehensive Marketing Plan

Develop a comprehensive Vermont health programs marketing plan that includes

- public education,
- professional training, and
- an outreach curriculum.

a. Make sure the message of the plan is broad and inclusive, such as "Vermont has programs to cover the uninsured" to address that continuum of uninsured with the continuum of programs, from Medicaid and VHAP through Dr. Dynasaur, Catamount Health Assistance, and Catamount.
b. Make sure that the message directs potential beneficiaries to sources of assistance, such as local, in-person resources, the toll free telephone Member Support line (with expanded hours), and effective web based tools. (See Appendix C for further detail.)
c. Make sure that the message is communicated in simple fact sheets and brochures about the programs for *primary* audiences (the general public of uninsured Vermonters as well as their friends and family) and for the *secondary* audience of human service and health care professionals.
d. Make sure that outreach "program marketing" materials, targeted to both primary and secondary audiences, are readily available in print and electronic formats.

B.4. Enable Web-based Tools

Create (or adapt) and provide training for a web-based "Vermont health programs" pre-screening and application intake tool.

a. Create two levels for the online tool:
    - Level one: a basic screening, to capture demographic information (name, contact information, etc.)
    - Level two, accessible to those with additional training, a full on-line application. (If the application process can be sufficiently streamlined and simplified, a direct consumer on-line application could also be developed, but there will still need to be an on-line tool that can be used by trained experts to walk applicants requiring assistance through the process.)[6]
b. Make sure information from the screening tool is captured and tracked to assure follow-up contact to complete the full application.
c. Create a "button" on the pre-screening tool that would signal the need for follow up by an outreach worker to provide direct assistance to the applicant.

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[6] Community Catalyst has launched a web-based enrollment tool (Real Benefits, www.realbenefits.org) that could provide a solution for Vermont. Bi-State, along with other work group members, have already begun to engage Director Besio in exploratory discussions about this and other web-based applications.

The screening tool should be widely available to uninsured consumers, family counselors, health care providers, social and human services case workers and care coordinators, insurance carriers and brokers, human resources professionals at large and small employers, and others across the state who will – collectively, at a community level – serve as the "front line" coordinators of Medicaid and Catamount outreach.

B.5. Implement Applicant Inquiry Tracking

Create a system for assuring that all individuals who self-identify or are referred and present through the screening tool are:

- tracked,
- offered one-on-one assistance with completion of a full application, and
- followed up to assure that they have applied, the resolution of that application, and added to statistical accountings in an outcomes data base.

Make sure there is a feedback system for health care and human services professionals that lets referral sources know the outcome of the referral and the next steps they need to take with the applicant, if any are needed. It is as important to track why applications were not successful as well as to track successful enrollment.

B.6. Deploy One-on-One Outreach Coordinators

Create a statewide cadre of Outreach Coordinators – volunteer and professional – similar to the effort that was mounted to assist in enrollment in Medicare Part D plans. The difference will be that instead of trying to enroll all eligible beneficiaries in a short time frame, this new Medicaid and Catamount outreach program will be doing incremental enrollment, sustained over multiple years. The Outreach Coordinators role is to provide the one-on-one eligibility and enrollment counseling and assistance to their *primary* constituency (the uninsured and other consumers) and serve as expert resources for the *secondary* constituency (of health care and human resources professionals).

C. Outreach Coordination in Detail

The experience in San Mateo County, California, detailed in Appendix B, provides confirmation of the work group's conclusion that a successful outreach effort needs to include the creation of Outreach Coordinators.

The work group recommends structuring the outreach coordination process into two broad categories along lay-person v. professional lines. All coordinators would receive "Outreach 101" training that provides them with knowledge of the state health care programs (from Medicaid through Dr. D, VHAP, Catamount Assistance, and Catamount purchase) and in how to guide individuals through the outreach screening intake tool from any internet connected computer.

Outreach Coordinators who choose to do so (supplemented by professionals recruited to support the process) will be trained in "Outreach 201." This coordinator training is designed for health care, social and human services providers, who can help provide one-on-one counseling and assistance to complete an on-line application for Catamount Assistance/VHAP/Dr. D./Medicaid. These coordinators would be considered "certified outreach counselors." It may also be effective to create an "intermediate level" of outreach coordinators for health care professionals who could do referrals of their patients directly.

Members of the work group did not reach consensus about the process for compensating outreach coordinators, but most agreed there is a cost to the activity that needs to be acknowledged and reimbursed in some fashion. Some suggested that the applications completed and submitted by certified outreach counselors (who have completed both levels of training) would be paid a stipend for each submitted application. (However this is resolved, the process needs to assure that the focus is on assuring wide availability of high quality information to serve the goal of enrolling more uninsured, not simply processing a higher number of applications.)

The work group recognizes that there are not presently direct sources of funding for an outreach coordination program, and that indeed, funds appropriated for outreach and enrollment as a whole are limited. The work group recommends that increased funds be made available in FY2008 to support outreach and enrollment, that Medicaid administrative match opportunities be fully utilized, and that the state actively pursue private funding sources with both state and national partners. (See "Leveraging Resources" below.)

Any payments to coordinators for outreach activities would need to be designed carefully to assure that they are coordinated and do not conflict with other grants or reimbursement programs (such as those associated with the schools).

If a payment system was adopted, the certified outreach counselors (and/or their employer organizations) would agree to participate in a coordinated "follow up" cycle over 15-30-60-90 days and then in 6 months, to track actual enrollment of applicants and follow up on incomplete applications, in exchange for accepting payment for application counseling and assistance. A database of screened applicants and filed applications could be compiled from the web-based intake tool.

Certified outreach coordinators could refer problems up to regional outreach counseling supervisor/trainer field staff (who could be employees of state government, public or private non-profit agencies, or both, supported through grant funding and state funds potentially matched by Medicaid).

D. Out-stationed Eligibility and Enrollment

Many states have developed an "out-stationed eligibility & enrollment worker" model

where either state agency employees or individuals or organizations deemed or certified by the state agency are empowered to complete the Medicaid application process with consumers in community settings such as hospitals, community action agencies, and clinics and health centers.

This is a step beyond outreach coordination, in that it would engage the applicant in more detailed discussion about eligibility for benefits. Because of the complexity of eligibility screens, income and resource tests, exclusions of certain income from the calculation, etc. detailed earlier, this process has historically been conducted only by state employees. Many state Medicaid programs have found it effective to broaden the cadre of people able to complete the enrollment process.

Many health centers across the nation have out-stationed eligibility and enrollment workers who are able to move the uninsured applicant directly through the process on-site. In Vermont, health center staff perform outreach coordination functions currently, but there is not an out-stationed eligibility and enrollment process in Vermont.[7]

With 26 FQHC sites in Vermont, this is a clear opportunity for outreach expansion. Bi-State has recently asked OVHA to revisit state policy and see how it can be integrated with efforts to maximize outreach and enrollment opportunities at the community level across the state, not just at FQHCs, but at Rural Health Clinics, hospitals, community action agencies, free clinics, and other community based organizations such as PATCH programs and family centers. OVHA Director Joshua Slen agrees that all strategies for maximizing outreach need to be carefully reviewed and indicates "all options are on the table."

The advent of the need for "in person" verification of citizenship and identity documentation under the Deficit Reduction Act (DRA) requirements brings new challenges for the enrollment process. In Vermont, where 80% of the Medicaid health care program applications are processed not through the district offices but through the Health Access Eligibility Unit (HAEU) in Waterbury – which is not set up for walk in visits – the combination of the DRA and enhanced outreach efforts argues for expanding the "points of access" into the system for applicants and empowering the certified outreach coordinators to verify citizenship and identity documents.

E. Additional Considerations

The work group learned that the original Maximus contract required Member Services to be located in a publicly accessible "store front" location. Maximus is currently located in

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[7] Under federal statute, state Medicaid agencies are required to pay Federally Qualified Health Centers (FQHCs) for out-stationed enrollment activities. Thirteen states are fully or mostly compliant with this requirement (meaning the state pays for the activity), 19 state are partially compliant (meaning the state pays some costs), and 17 states, including Vermont, are non-compliant (meaning there either are no out-stationed workers or that the costs for the work are paid for entirely by the health centers). *National Association of Community Health Centers, 2006 PCA Survey Data*

downtown Burlington, off the Church Street Marketplace, but in a fourth floor office suite. Work group members suggest location of Member Services in a more consumer-accessible location (possibly co-located with an AHS District Office), as well as the use of outreach through shopping mall kiosks and county and regional fairs in the summer months.

An important role for outreach coordinators, although not their primary role, would include providing public education, in the form of presentations about the various program offerings through Rotary, Chamber mixers, downtown associations, volunteer rescue squad auxiliaries and trainings, churches, the schools. However, as noted before, this sort of general public education and awareness campaign is not a substitute for extensive, targeted, one-on-one outreach aimed at seeking out the uninsured where they live, work, and play/shop/attend church and engage with their communities.

In addition, a program of succinct, direct, on-site education and training for health care professionals will need to be designed and delivered, in collaboration with the Vermont Medical Society, Vermont Association of Hospitals and Health Systems, the Vermont Area Health Education Centers network, and Bi-State. These should be targeted toward urgent care clinics, emergency departments, medical staffs, practice managers, and front-desk/intake staff and be integrated into existing professional educational programs.

F. Leveraging Resources

Many organizations within and outside the state are very interested in supporting the successful implementation of Vermont's health reform legislation. Opportunities for working with national organizations that have already expressed interest such as the Robert Wood Johnson Foundation, the Heinz Family Philanthropies, America's Agenda, and Community Catalyst should be vigorously pursued. As noted above, Bi-State and other work group members are actively collaborating with Director Besio to pursue grant funds and other resources.

Within the state, several organizations including VT NEA, VT AARP, and the Vermont Citizens Campaign for Health, working together as the Campaign for Healthcare Security, have just established the Vermont Health Care Security Education Fund, a corporation organized exclusively for educational purposes under section 501(c)(3) of the Internal Revenue Code. These organizations are so committed to the success of health reform that they felt the need to create this new, non-profit foundation and are actively seeking funds to support an integrated program of outreach and enrollment in partnership with state government.

According to its bylaws, the Fund "is committed to creating and supporting educational initiatives that facilitate public understanding of and expand access to the Catamount Health Plan and other publicly funded state health insurance programs, particularly for the most vulnerable citizens of Vermont." It is also "committed to educating Vermonters about the benefits of making health care available and affordable to every citizen,

eliminating barriers to care, ensuring the adequate funding and financial sustainability of Vermont's health care system, and improving the safety and quality of health care delivery."

G. Other Recommendations

Related to the primary outreach constituency, consumers:

- Extend evening and weekend hours for the Member Services toll-free number and an expanded capacity for phone support to individuals completing paper applications.
- Do not expect "traditional media" publicity (TV and radio public service announcement, newspaper advertising, etc.) to be the main carriers of the outreach message.
- Place a special focus on particular target populations every three-to-six months (children, adults working in small businesses, at risk youth, etc.) that allows marketing efforts to be more targeted on a rotating basis. Attempts to outreach to every population all the time are not sufficiently focused to have the impact more targeted campaigns could yield.
- Have the state tax department send out outreach brochures in tax mailings.
- Integrate health program applications with the application for the free and reduced price school meals program. (For fall 2007, this would require action and coordination in early winter 2007.)
- Integrate Medicaid and Catamount outreach information with school sports program insurance materials distributed to students and parents.
- Target, target, target. Send outreach coordinators to find low and middle income adults and children without health coverage where they live. Target outreach to specific areas where eligible but un-enrolled families are clustered: trailer parks, low- income housing units, child care centers, unemployment offices, Burlington's North End, the Northeast Kingdom and other poor, rural communities. Use income distribution data by towns to identify geographic priorities.
- Experts agree: the primary target audience are the working poor. A child center director explained in an interview: "look any place where people are employed at low-wage jobs or several part-time jobs. People in real poverty get health benefits, people who earn moderate incomes make too much to qualify for Medicaid, don't receive health benefits through their employer, and can't afford the premiums. That would be people in retail, service jobs like restaurants, housekeepers, seasonal jobs, landscapers, tourist industry, ski industry, carpenters, housepainters, and the list goes on."

Related to the secondary outreach constituency, health and human service professionals and other community level professionals who can assist consumers:

- Create a special line for outreach coordinators to reach Maximus Member Services staff directly.
- Create a standing weekly phone meeting for Maximus, AHS staff, and outreach coordinators to call in to triage, review, and troubleshoot application and recertification cases that have encountered a "glitch" in the system.
- Engage public libraries and town clerks in outreach. Look to the local community champions and informal resources: they know the people of their community best. Ask them where they would direct outreach.
- Challenge communities (village, town, or county level) to develop and implement their own outreach programs targeted to the specific needs of their communities, integrated with the statewide efforts, the local district Health Department offices, AHS regional partnerships, local health care providers, and others. Local United Way agencies may be able to help with outreach or identify organizations in the community that can.

Related to structural issues:

- Centralize responsibility and accountability for marketing and outreach materials across state government and interested partners to assure they are updated on a timely basis.
- Minimize printing of brochures (because of their tendency to rapidly go out of date), instead utilizing web-published materials that can be easily updated and printed in smaller quantities by community organizations and providers.
- Support work VDH has undertaken to improve and rationalize web-based information on programs.
- State agencies would benefit from a continuing shift in focus to examine the needs of the uninsured more from the consumer perspective.
- Expanding on that theme, to design better approaches and systems, *start with the premise the consumer knows nothing about Medicaid, VHAP, Dr. Dynasaur, Catamount Health, Employer Sponsored Insurance or any other public health care program*. All the consumer knows is they are worried about their future needs for health care; they don't have health coverage and have a vague idea that the state provides something for individuals like themselves and their children. What would they first try to do? Where would they start? Who would they call? What would they type into a web search engine? What would they look for on state government web sites? What do they look for in the phone book?
- Some of these difficulties are related to the organizational structure of state government. The departments are still too often in individual silos and oversee separate but related programs. The recent AHS reorganization efforts moved the

Agency in the right direction, but there is more work yet to go. Organizing efforts around the needs of the consumer could help focus that work.

A National Governor's Association (NGA) issue paper, "Improving Access to Benefits for Low-Income Families" (August 2006), identifies several approaches states can use to make it easier for low-income families to obtain and retain benefits, including:

1. "using the Internet to develop tools that determine eligibility for multiple programs and create online applications;
2. creating single applications for multiple programs so families can apply for several benefits through one application;
3. establishing call centers and co-locating services within local organizations that have strong connections to working families;
4. aligning program policies regarding eligibility, verification, and renewal so that benefit requirements are coordinated."

The paper notes that states should make sure that they are currently using the "flexibility the federal government has given states to align and streamline:

1. eligibility requirements,
2. verification processes,
3. renewal procedures, and
4. program applications."

"By doing so, low-income families can determine whether they are eligible for benefits, how to begin obtaining services, and how to continue to receive support. Aligning policies provides a more cohesive and streamlined system for states while reducing redundancies and costs. As many of these programs serve the same families, states can analyze where duplication of efforts exists to improve the system while maintaining program integrity." (*NGA issue paper*)

These recommendations echo discussions in Vermont related both to the "Global Commitment" 1115 Medicaid waiver and health reform legislation, but it is worth reiterating the need to make sure the state is taking full advantage of applicable federal policies.

VI. Conclusion

The scope, scale, and ambition of Vermont's health reform initiatives demand an equally ambitious response to the challenges of outreach and enrollment. Given the timetable for implementation of Catamount Health and the compelling logic for integrating outreach and enrollment of both Catamount and the Medicaid health care programs, strong leadership within state government, in partnership with private organizations, health care professionals, and human services agencies and organizations, is required to assure that a comprehensive outreach and enrollment program is developed and ready to go to support the new and existing state coverage initiatives.

Whatever the final design of the outreach program, the underlying recommendation is quite simple: to maximize enrollment, Vermont needs both a comprehensive marketing plan and people on the ground to assist potential applicants in completing the application transaction. This integrated approach needs to include a mechanism for initial eligibility information/screening that captures the potential applicant's basic demographic data, submission of an application either directly after screening or by subsequent referral, and follow-up to track the status of enrollment. (The experience in Florida, detailed in Appendix A, provides instructive examples.)

Throughout the work that informed this report, a wide array of individuals and organizations voiced a strong desire for success. By tapping into that well of support, state policy makers and administrators have an excellent opportunity to create a more effective, comprehensive outreach and enrollment program, expand coverage, and reduce the number of uninsured Vermonters. Partnerships are already emerging through the discussions that have begun this summer and fall, and together, many individuals and organizations are ready to rise to the challenges the legislature, the Governor, and the people of Vermont have voiced to expand access and coverage for all Vermonters.

Appendix A: Best Practices for Outreach and Enrollment Identified by the NGA

Introduction

As Vermont plans to expand its use of the Internet to improve access to benefits and expand outreach programs, stakeholders should be encouraged to review the experience of other states. The National Governors Association (NGA) Center for Best Practices recently published a report on this subject. Their August 2006 report "Improving Access to Benefits for Low-Income Families" surveys the use of the Internet to reduce the barriers to benefits. These benefit programs include Medicaid, Temporary Assistance for Needy Families (TANF), state children's health insurance programs (SCHIP) and child care subsidies. Using selective excerpts from the NGA report, this appendix highlights the efforts of four states: Florida, Pennsylvania, Washington, and Wisconsin.

Developing a Comprehensive State Approach to Improve Access to Benefits

Several states have developed comprehensive approaches to integrate access to benefits by increasing outreach efforts, bundling services, aligning program requirements, simplifying benefits, and using technology.

Florida

Florida has pursued several strategies to modernize the state's model of delivering support services to families in response to changes in customer needs and a legislative directive. The new model stems from the recognition that although the number of families receiving TANF cash assistance in Florida is low, the number of families receiving food stamps and Medicaid services is increasing – a signal that more working families are in need of assistance. The goals of the new system, **ACCESS Florida**, are to increase opportunities for customers to access self-service products, simplify policies to reduce staff and customer error rates, and reduce administrative costs for the state.

With the new ACCESS Florida system, families now can apply for benefits through community partners, online applications, Florida Department of Children and Families (DCF) offices, mail and fax. Changes to the system were based on suggestions from department case managers and customers, allowing new business practices to reflect the needs of the consumer. Back-end support services and production-oriented processes (e.g., fraud detection, claims processing) are conducted in offices "behind the scenes" to allow case mangers to deliver benefits and services to clients in a faster and more seamless manner. Since the implementation of Florida's new program, error rates have decreased and the state has achieved a 35 percent reduction in staff with an 18 percent increase in workload.

As part of Florida's multifaceted approach to delivering benefits, over 2,000 community partnerships have been developed through the ACCESS Florida program that play a critical role in expanding access to services for working families. Partners include workforce one-stop career centers, homeless services organizations, hospitals,

faith-based organizations, and community centers. Such partners guide families through the online application process and can offer additional assistance when families apply for benefits (partners do not screen for program eligibility). The enhanced Web application, also an integral component of ACCESS Florida, allows clients to apply for benefits online through electronic signatures and has rapidly grown in use. As of June 2006, over 85 percent of the state's applications for benefits were received electronically.

Automating information and application processes allows caseworkers to spend less time on administrative activities and more time providing direct service to clients. After implementing its online ACCESS Florida system, the state of Florida has saved $83 million in administrative costs.

Many other states, while less comprehensive, are using the Internet to facilitate the integration of service delivery and streamline access to programs. Online resources can make it easier for families to locate information on multiple programs and apply for benefits. Using technology to integrate benefits also helps states by improving the efficiency and effectiveness of public resources. As more and more people turn to the Internet to find information and obtain goods and services, states can tap into this vital resource to improve program access.

Benefits of Online Services

There are multiple benefits for low-income families when services are provided online. With access to information and the potential ability to submit applications any time, families are not limited to applying for benefits in-person at local offices within specific timeframes. This can be very important, especially for working parents who might not have flexible employment schedules and families with transportation barriers.

Online Screening and Benefit Calculators

All states post information about benefits on the Internet and most have program applications that can be printed out and submitted via regular mail or in person. In addition to these features, states can develop other online tools to simplify and streamline access to benefits including:

- screening tools to determine eligibility for multiple benefits;
- calculators that provide a rough estimate of potential benefits; and
- online applications that allow families to apply for multiple benefits.

Approximately one-fourth of all states now offer online screening and benefit calculator tools that can simultaneously determine a person's eligibility for multiple services. Online calculators differ from screening tools by providing potential clients with a rough estimate of the benefit amount they could receive from support services. Given that the purpose of online screening and benefit calculators is to provide a quick assessment of program eligibility, states should design these tools to be as user friendly, comprehensive, and brief as possible.

The tools also should provide information on how families can apply for benefits with potential links to online applications. Similar to other state programs, the **ACCESS Wisconsin** system allows individuals who have completed an online eligibility tool to print out program applications and provides telephone numbers and addresses of local offices to apply for benefits in person. The website also lists what types of documents individuals should bring when applying for benefits at local offices. ACCESS Wisconsin screens for food stamps; medical assistance; state children's health insurance program (BadgerCare); tax credit programs; Women, Infants and Children benefits; and free and reduced-price school meals.

The more programs included in an online screening tool, the more time-consuming the screening process is likely to be for clients. States will want to strike a balance between screening for the broadest array of programs as possible, while minimizing the complexity of the tool. Some states have designed screening and benefit tools so answers to specific questions trigger a subset of questions for more targeted programs, such as those intended to assist individuals with disabilities. This approach reduces the number of questions individuals must answer unless they meet basic program requirements. Screening tools also can determine whether other individuals in a person's household might be eligible for benefits.

Applying online

Several states have gone beyond screening and calculator tools by developing Web sites that allow individuals to apply online for multiple benefits.

Pennsylvania

One of the best known efforts to offer access to benefits in an integrated, electronic format is **Pennsylvania's COMPASS** program. Launched in 2001, COMPASS offers an online screening and application program for healthcare programs, TANF cash assistance, food stamps, energy assistance, and community and home-based services. The program provides customers the ability to screen, apply, renew, and check benefits and the status of their application. A network of community partners can assist clients who are applying for benefits through the COMPASS system, offering a critical service to enhance outreach efforts to low-income families. Tools that facilitate a simplified process for customers include lists of the verification documents required for each program, e-signed applications and renewals for clients to continue receiving benefits, and a generic health care application that is routed to the appropriate department to determine whether the client or family member could be eligible for Medicaid or other health services. Future enhancements to COMPASS include adding programs provided through the Pennsylvania Departments of Health and Aging, scanning verification documents, offering online applications for the national school lunch program, and providing automated program renewals in which packets will be generated and mailed to clients.

Washington

State has developed an online program that allows families to apply through the Internet for multiple benefits including food stamps, TANF cash assistance,

Medicaid/SCHIP, and child care. In addition, the online application allows individuals to apply for drug and alcohol treatment services and long-term care assistance and renew benefits for multiple programs. Data submitted through an online application are reviewed by an eligibility caseworker and entered into the state's mainframe system.

Wisconsin

The newest component of **Wisconsin's ACCESS** system is an online application for food stamps and family Medicaid programs (including BadgerCare) implemented in June 2006. The state tested the new online application in several community-based agencies to determine how to make the application most effective. ACCESS Wisconsin includes a feature that allows for the automatic transfer of data from online applications directly into the state's eligibility determination system, eliminating the need for caseworkers to reenter information. Future plans to expand ACCESS Wisconsin include allowing Medicaid and food stamp program participants to report changes in their employment status to caseworkers.

Appendix B: The San Mateo Experience and Comparison to Vermont

This appendix will focus on the San Mateo County approach to outreach and enrollment of children and families in public health care insurance programs. Surprisingly, San Mateo County and Vermont have many similar demographics; total population, percent of those under 18 years of age, percent of seniors and number of households. The biggest differences are San Mateo's incomes and population diversity and Vermont's more rural character. However, overall these statistics and those at the end of this appendix suggest there are enough similarities to make the experience of San Mateo meaningful for Vermont.

	San Mateo County	Vermont
Populations	699,610	623,050
Persons under 18	23.3%	21.7%
Persons 65 and over	12.8%	13.0%
Households	254,103	240,634

But, there are also some differences:

	San Mateo County	Vermont
Per capita income	$36,045	$20,625
Median household income	$64,998	$42,649
Persons per square mile	1,574	65.8

In 2000, San Mateo County in California established the Children's Health Initiative (CHI) with a goal of enrolling every eligible child in the county into this health insurance program. The county set up a successful outreach program to identify children and then to enroll them if they qualified for CHI. This program also provides families with information about other health programs and social services.

To evaluate the success of the program, the county hired outside organizations -- the Urban Institute, University of California at San Francisco and Mathematica Policy Research -- to do a series of annual reports. The information in this Appendix is based on the first three of five evaluation reports for 2004, 2005, and 2006.[8]

[8] Reports are available on the web at www.urban.org.

There are three main components to the San Mateo Outreach and Enrollment Program:

- **Outreach Events and Publicity**: The County concluded that large media campaigns explaining the program were not effective. However, sponsoring community health fairs proved to be very successful. Radio spots and community canvassing attracted potential enrollees. Thirty application assistors took applications. The early events enrolled 700 people. Today, the fairs enroll 20-30 families per event.

- **School-Based Outreach:**Twelve of the 18 school districts in the county participate in the Outreach and Enrollment Program. The primary vehicle for school-based outreach is the Request for Information (RFI). The RFI contains health options and is sent home with the children. Parents wishing to be contacted fill out the form and return it to school. Interested parents are then contacted by an application assistor to help them through the process to determine eligibility and to enroll in the appropriate program. The RFI also contains information about other programs like free and reduced price lunches.

- **Outreach Workers**– there are four types of workers involved in outreach and enrollment. Sometimes there is overlap in the categories:

  A. **Certified Application Assistors (CAA):** CAAs receive one day of training to help families enroll in Med-Cal and Healthy Families. There are 130 CAAs in the county (population 699,000). Salaries are covered by organizations CAAs work for.

  B. **Outstationed Community Health Advocates (CHA):** CHAs are certified as CAAs and work as application assistors. These CHAs are outstationed in community based locations (schools, free-clinics) and coordinate outreach/enrollment events. The county has five outstationed CHAs. Salaries are covered by the Children's Health Initiative.

  C. **San Mateo Medical Center CHAs:**Ten CHAs are employed at the Medical Center, a fully accredited 509 bed acute and long term care hospital. The CHAs work exclusively with the Medical Center patients. Salaries are paid by the Medical Center.

  D. **Benefits Analysts (BA):** BAs are employed by the Human Services Agency and do traditional case work. They determine enrollment eligibility for Med-Cal, Healthy Families and Healthy Kids.

"In-reach"is a part of the San Mateo enrollment effort – this method identifies children needing health insurance as they enter health and social service programs.

Result of outreach enrollment efforts:

During the 2005-2006 school year, more than 2,900 questionnaires were returned with 72% of the families requesting assistance in applying for the CHI and other programs. Data is not available documenting how many of these families actually enrolled their children in the health insurance program.

School districts with a strong commitment to the process experienced the highest rate of returned questionnaires. In one school district, the California Teachers Association sponsored Teachers for Healthy Children to promote children's health insurance programs. Another project engaged school nurses to connect children and their families to CHI.

Interestingly, more children are enrolled in clinics rather schools. For the school districts to be most effective, the county determined they needed to target schools with the greatest needs.

The source of enrollments breaks down as follows:

- Medical Center Community Health Advocates (CHAs) enroll 42% entering the Health Kids Program
- Certified Application Assistors (CAAs) enroll 31%
- Health Services CHAs enroll 16%
- Human Services Benefits Analysts enroll 11%

Other Programs

The US Department of Health and Human Services published a "Review of the Literature on Evaluations of Outreach for Public Health Insurance and Selected Other Programs." [9] Readers may want to review this document to gain insights into outreach and enrollment programs. The report provides a "synthesis of the empirically-based evidence on the effectiveness of interventions to increase enrollment of low income children and families in public health insurance programs."[10] The report focuses on state SCHIP and Medicaid programs.

[9] Barents Group (Washington, DC) prepared this report for the Agency for Healthcare Research and Quality Center for Organizational and Delivery Studies (Rockville, MD); published March 2000.

[10] AHRQ report, page iii.

San Mateo County and Vermont have many similar demographics.

People QuickFacts	**San Mateo County**	**Vermont**
Population, 2005 estimate	699,610	623,050
Persons under 5 years old, percent, 2004	7.0%	5.0%
Persons under 18 years old, percent, 2004	23.3%	21.7%
Persons 65 years old and over, percent, 2004	12.8%	13.0%
Persons with a disability, age 5+, 2000	107,440	97,167
Housing units, 2004	265,507	304,291
Homeownership rate, 2000	61.4%	70.6%
Median value of owner-occupied housing units, 2000	$469,200	$111,500
Households, 2000	254,103	240,634
Persons per household, 2000	2.74	2.44
Per capita money income, 1999	$36,045	$20,625
Median household income, 2003	$64,998	$42,649
Persons below poverty, percent, 2003	6.8%	9.2%
Business QuickFacts	San Mateo County	Vermont
Private nonfarm establishments, 2003	19,453	21,831
Private nonfarm employment, 2003	323,302	256,441
Retail sales per capita, 2002	$12,858	$12,366
Federal spending, 2004 ($1000)	3,491,778	4,632,933
Geography QuickFacts	San Mateo County	Vermont
Land area, 2000 (square miles)	449	9,250
Persons per square mile, 2000	1,574.7	65.8

Source: US Census Bureau State & County QuickFacts

Appendix C: Outreach Resources Matrix

As the table indicates, the work group suggests an array of resources can contribute to, and assist with, outreach and enrollment. Consistent, comprehensive screening and programming information constitutes the first tier resource, assistance with applications the second tier, and actual eligibility determination and enrollment the third tier. Some resource sites will be able to address only the first tier, others additional tiers. This list is suggestive, not exhaustive.

Resources	**Screening and Program Information**	**Application Submission**	**Enrollment (out-stationed or on-line)**
On-Line Access			
Consumer on-line web portal	X	X	
Outreach Coordinator web tools	X	X	
Physical Access Points			
District AHS Offices	X	X	X
District Health Dept. Staff	X	?	
All medical practices	X		
Practices with trained coordinators	X	X	
FQHCs	X	X	?
RHCs	X	X	?
Free Clinics	X	X	?
Hospital ER	X		
Hospital Financial Offices	X	X	
Hospital Social Service staff	X	X	?
Home Health Agencies	X	X	
Youth centers/agencies	X	X	
Community Action Agencies	X	X	
Ombudsman, Legal Aid	X	X	
Food banks, meals programs	X	Some	
Area Agencies on Aging	X	X	
Family Centers	X	X	
PATCH sites	X	X	?
AHS Regional Partnership organizations	X	Some	

Resources	Screening and Program Information	Application Submission	Enrollment (out-stationed or on-line)
Physical Access Points (continued)			
State Health Insurance Assistance Program staff	X	X	?
Homeless shelters, drop-in centers	X	X	
Schools, libraries	X	X[11]	
Town Offices, Town Halls	X	X[12]	
County Court Houses	X	X[13]	
Rescue Squads and Fire Departments	X	X[13]	
Churches, Synagogues	X	Some	
Business Human Resources offices	X	X	
Small business owners	X		
Community volunteers	X		
Insurance brokers and agents	X		
Commercial insurance carriers offering Catamount	X		

11 Capacity enhanced for periodic on-site Enrollment Drives

12 Like the schools and libraries, periodic drives could advertise "Registration Enrollment for Health Care to be held on [DATE] from [0] a.m. to [0] p.m." utilizing regional outreach coordinator resources.

Appendix D: Work Group Participants and Other Key Informants

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